DESCRIPTIVE FOLLOW-UP EVALUATION OF THE EARLY CHILDHOOD MENTAL HEALTH (ECMH) INITIATIVE (FISCAL YEAR 2004)

Submitted to the Kentucky Department of Public Health (Adult and Child Health) and Department of Mental Health and Mental Retardation (Division of Mental Health), Cabinet for Health Services by:

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Evaluation Summary

The Early Childhood Mental Health program experienced rapid growth in the number of children referred and served; and it experienced increased stability as specialists became more proficient in their roles and programs were integrated into their communities. All fourteen regions reported operating at capacity.

There were a number of trends in the second year relative to the first:

- Year 2 of the program saw a significant increase in the number of cases referred (778), accepted (578) and engaged (454) in the program. Referrals increased by 165% (from 471 in year 1); acceptances increased by 140% (from 413 in year 1); and the number engaged in treatment increased by 212% (from 214 in year 1).
- Externalizing behaviors continued to be the most dominant child behavior problems.
- Intra-family risk factors (i.e. parent-child interaction problems, family conflict, multiple family stressors) along with low socio-economic status continue to be significant problems for this population.
- Most families continue to have access to adequate nutrition, child care and health care.
- The percentage of engaged caregivers for children increased from 40% in 2003 to 57% in 2004.
- While service delivery rates in the second year were similar to the first, there was a decrease in the rate of individual therapy provided directly by specialists.
- The decrease in the rate if individual therapy was off-set by high rates of training to parents and mental health professionals and consultations to child care centers were provided by specialists in 2004, in accordance with program goals.
- More children were identified as being at risk for discharge from their child care centers in 2004 and more children were successfully maintain than in the first year. However, the rate of discharge was about the same.
- Similar to 2003, goal attainment rates for 2004 were fairly high, particularly for reduction of problem behaviors, improvement in parenting and improvement in parent-child interactions.

In its second year, the Early Childhood Mental Heath program was successful in providing much needed services to a significantly greater number of families and children than in its first. Outreach, public awareness and marketing activities have been very effective in this respect, as have the specialists' direct

services. With larger case loads, it is likely that specialists' placed more of an emphasis on parent training and caregiver consultation than in the previous year in order to be more time efficient and to reach more of those in need.

The program has been successful in reducing problem behaviors in children, improving family relationships and increasing family protective factors for a greater number of families and children in 2004. This is shown in the graph titled "Goal Attainment Among Completed or Nearly Completed Cases" on page 7.

A major goal of the ECMH program is preventing the discharge of children from child care centers. A greater number of at-risk children were reached and successfully maintained in their placements than in the previous year.

Specialists were very upbeat and positive about the impact that the program has had on children and families and report that, in general, it has been well received by their communities. While there are several ongoing issues that are frustrating for them, the specialists feel a sense of accomplishment and that their efforts are making a difference in their communities.

There are several recommendations that program administrators and planners might consider for program improvement:

- Child behavior management continues to be a central focus of the program. It is recommended that specialists' efforts concentrate on the teaching of behavior management skills to parents and child care centers.
- While appreciative of assistance, child care centers are often reluctant to contact specialists and may do so only in crisis. This is less efficient and effective than dealing with problems before they become a crisis. Continuing to focus on building collaborative relationships with child care centers, through training and consultation with front line staff and directors should help to alleviate this problem.
- Specialists reported the current staffing patterns of the program to be insufficient to meet the extensive needs of children in their regions. Also, some regions are quite large and require considerable driving time for specialists, which takes time away from other important duties. Additional staff would make the program more effective in reaching a greater number of families and children. In addition, with more staff, specialists would have the time to focus on those difficult to engage families and address problems before they reach crisis proportions.

How the evaluation was conducted

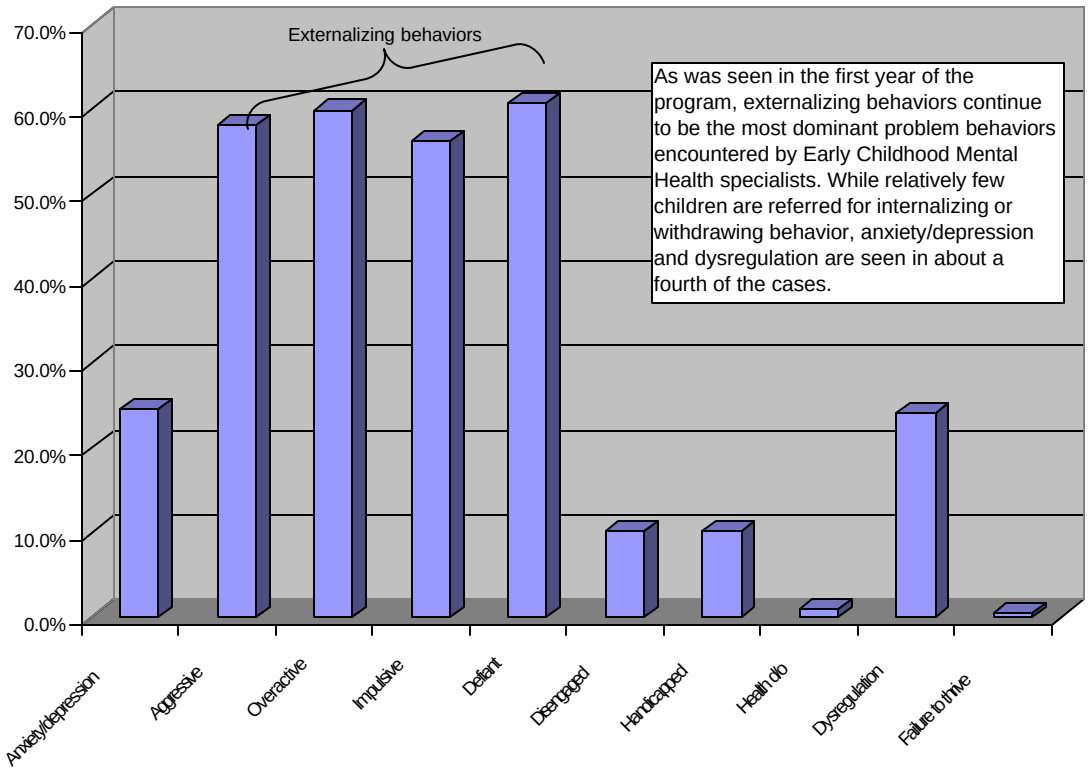
In June, 2004, interviews of about 45 to 60-minute duration were conducted by telephone individually with the ECMH specialist in each

region. The data gathered was on cases referred between July 2003 and June 2004. Specialists were provided a copy of the interview format prior to the interview, and were asked to organize and aggregate their case-level data for this purpose. The interviews began with discussion of the coordinator's background, regional characteristics, service needs, and service array. Next, analysis of the progress and extent of individual-level service offerings was performed. Finally, group and community level intervention descriptions were obtained. These data were then aggregated, and form the basis for this report. The results are limited to the accuracy of the data reported by each center. While it was felt that that the results are not as precise as might be gleaned from an automated data system, for the present purpose they were sufficient.

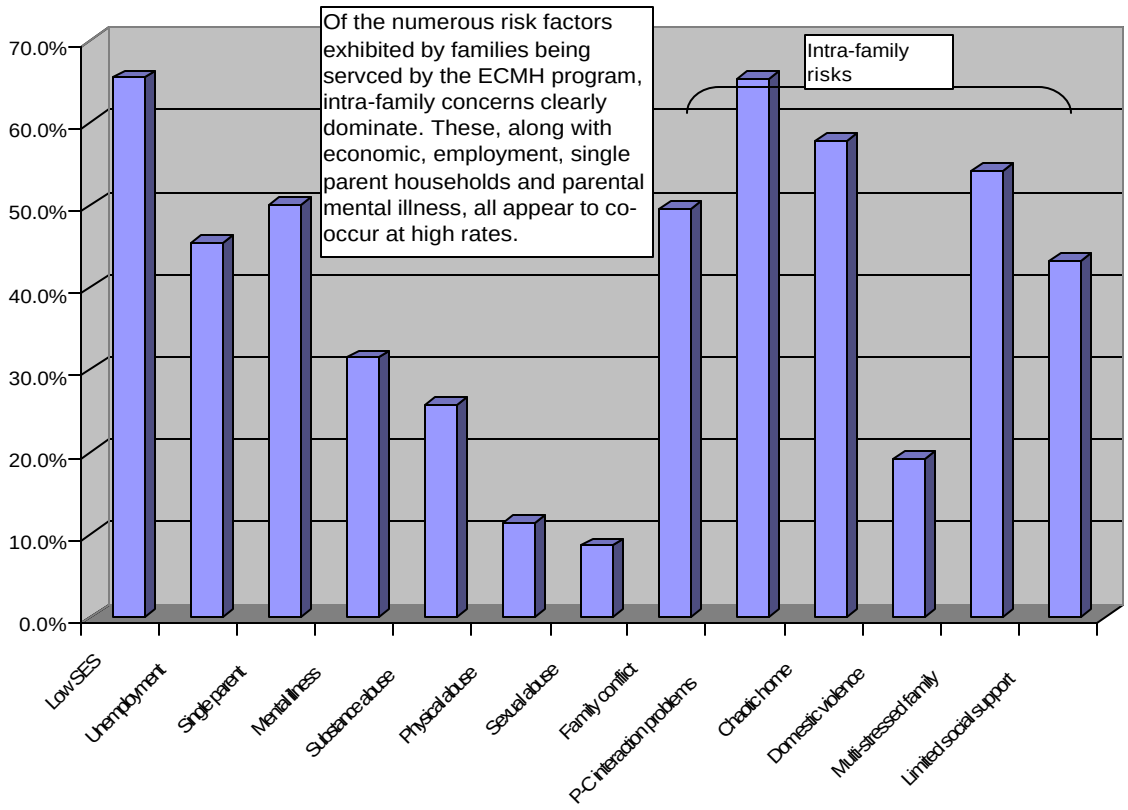
The structured interview methodology was chosen because of its efficiency and appropriateness considering the constraints of time and funding. This methodology is consistent with the methodology used in the 2003 evaluation.

Characteristics of children and families served by the ECMH program

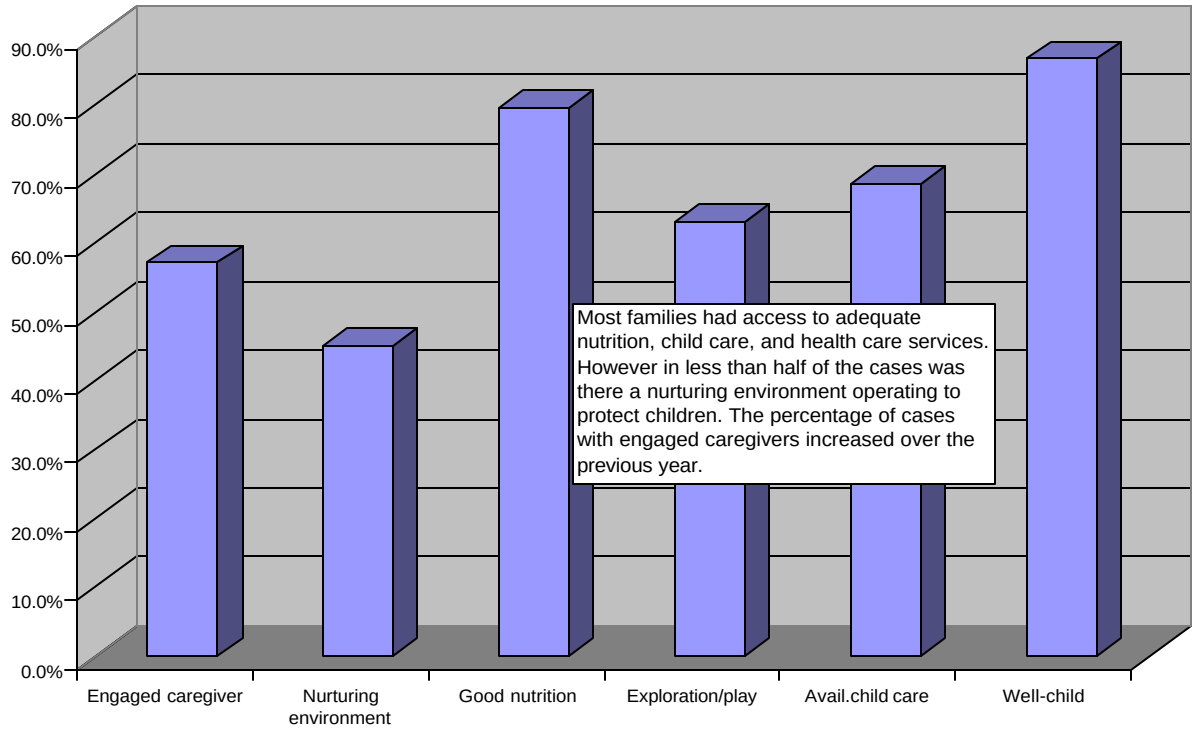
Child Presenting Problems Among ECMH Participants



Family-Level Risk Factors Among ECMH Participants



Resilience/Protective Factors Among ECMH Participants

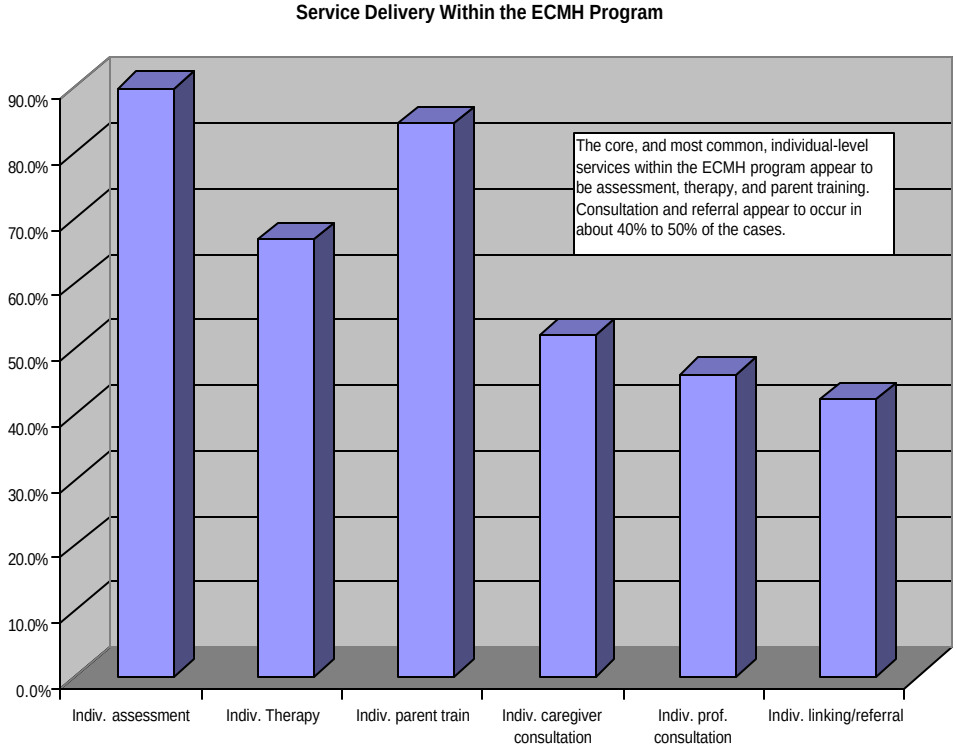


Program implementation and program activities employed at the individual level

The ECMH specialists were expected to employ several core activities that were outlined in the program guidelines. How these activities are implemented vary and are based on the unique needs of each region. The core activities are:

- Assessing
- Intervening
- Linking
- Coordinating
- Consulting
- Educating

The specialists' activities are focused across multiple levels and systems: (1) child and family level; (2) program level; and (3) community/system level.



- *ECMH specialists' qualifications*

  While each specialist met criteria for the position as outlined on the program guidelines, their background and training varied widely. Over half of the specialists had primary training and experience in mental health, including psychology (doctoral and master level), clinical social work, and mental health counseling. Others had backgrounds in early childhood education, child development, special education and occupational therapy.

- *ECMH Specialists' activities*

  The specialists exhibited a variety of approaches to organizing and implementing their program activities, as was the case in the previous year. Most of them engaged in activities across the various levels of the service system, necessitating a multi-service set of program offerings. In these cases, the specialists provided clinical services directly to children and families, in addition to providing consultation and education. On the other hand, a few specialists viewed their role as being one of referring and linking families to treatment and providing consultation and education to other professionals. Few, if any, individual-level services were offered by these specialists, as adequate treatment resources for ages 0 through 5 existed in their regions.

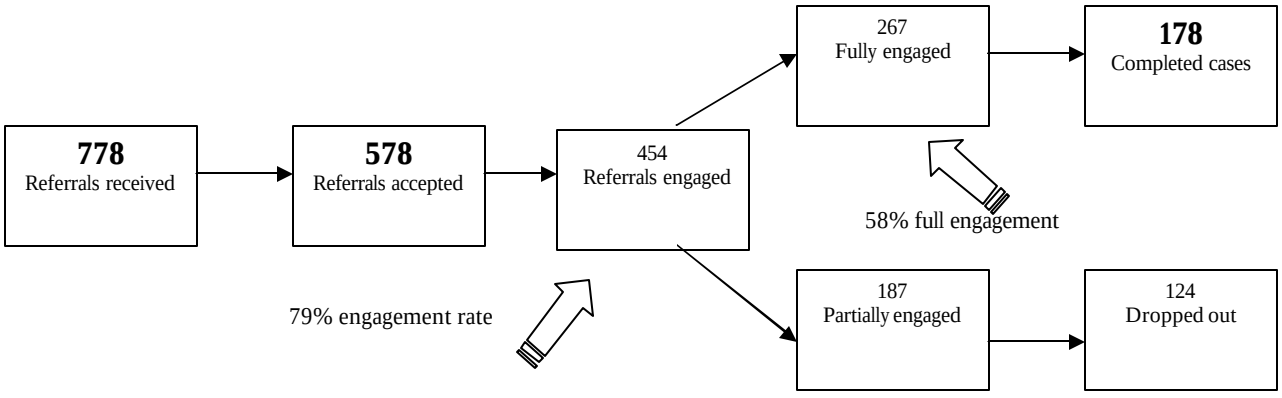
  All specialists reported their programs to be fully implemented and operating at capacity. They also seemed to have a clear understanding of the needs of children age 0 to 5 in their communities, and articulated these readily. The particular theoretical beliefs and working style of the specialists seemed to determine their approach to the needs of the client population in the community. Because the specialists operate within comprehensive care centers, the organizational culture of their centers also seems to have an impact on how they approach their role. For most of the specialists, community needs, personal style and organizational requirements matched well, resulting in the program operating effectively. While all viewed their programs as being effective, there were instances where the specialists felt that demands of the center made them less so (role definition, turf issues, co-worker support). As was the case in the previous year, operating an outreach and community based service delivery program within an office based model is still an issue for some. All specialists indicated that the need for services in their communities continues to be great, in spite of their efforts, suggesting the addition of more specialists.

- *Referral sources*

  Similar to the findings from the 2003 evaluation, specialists cited self-referrals and child or day care programs as being the most common sources of referrals. DCBS, First Steps, HANDS/Healthy Start and local physicians were also sources of many referrals. Although less frequent, many specialists reported continued contact with Head Start programs in the form of referrals and requests for consultation.

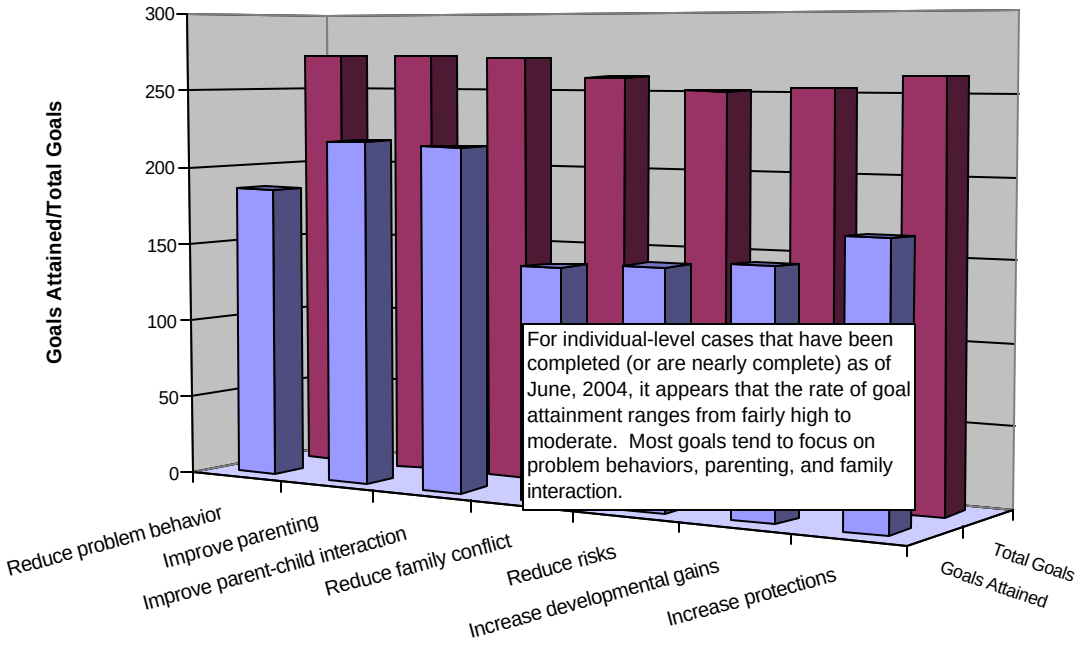
  While all of the specialists agree that they are providing services to the children and families with the greatest needs, they also report that many families are very difficult to engage in the treatment process. Some parents avoid getting involved in treatment due to the stigma associated with it, while others request assistance only during periods of crisis, refusing services once the crisis has been resolved. These families, who are often the most needy and at risk for acute and chronic problems, continue to present an ongoing challenge for the specialists in their attempts to provide services.
  For year 2004, the number of cases referred, accepted and engaged increased over the previous year. These increases are likely due to the program being more established and accepted in the communities.

- *Cases referred, accepted, engaged and completed/closed during 2004*

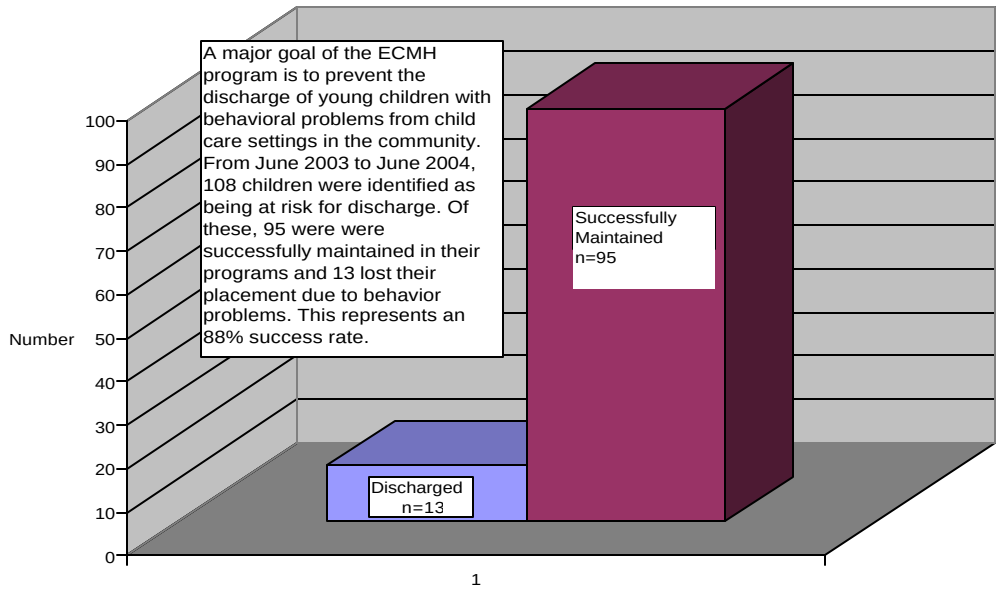


Outcomes for completed cases: Problem reduction, developmental milestones, parenting, risk reduction

Goal Attainment Among Completed or Nearly Completed Cases (N=272)



Engaged Children At Risk for Discharge from Child Care Settings in the Community (n=108)

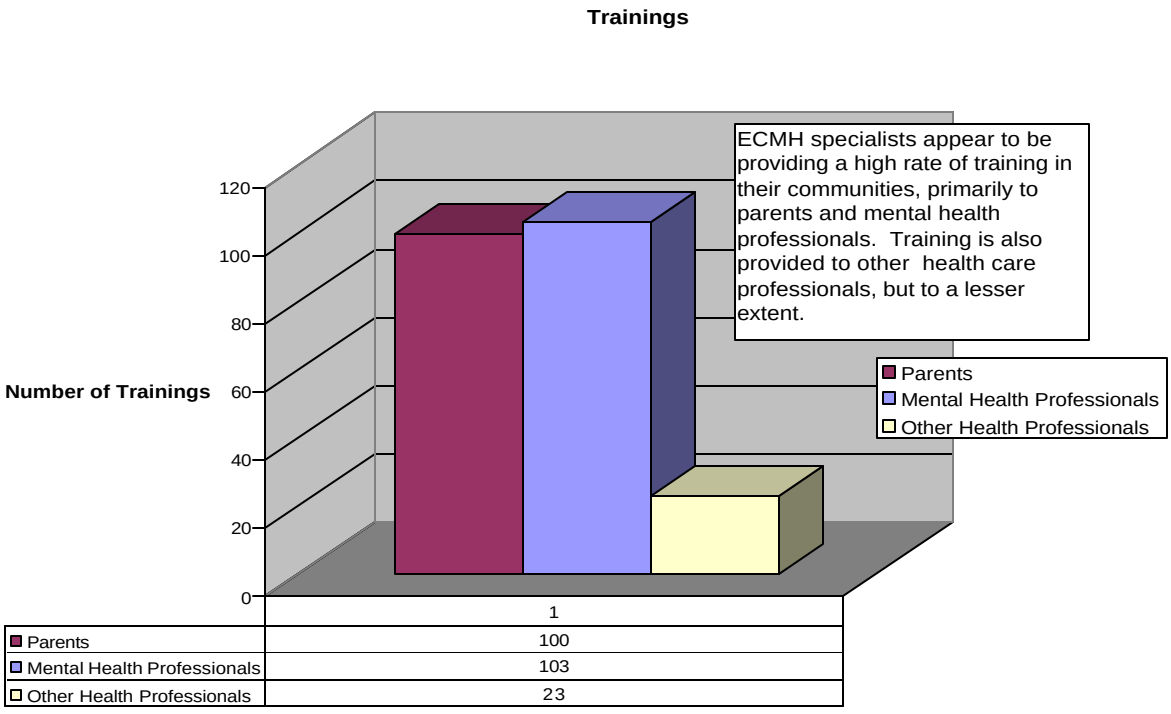


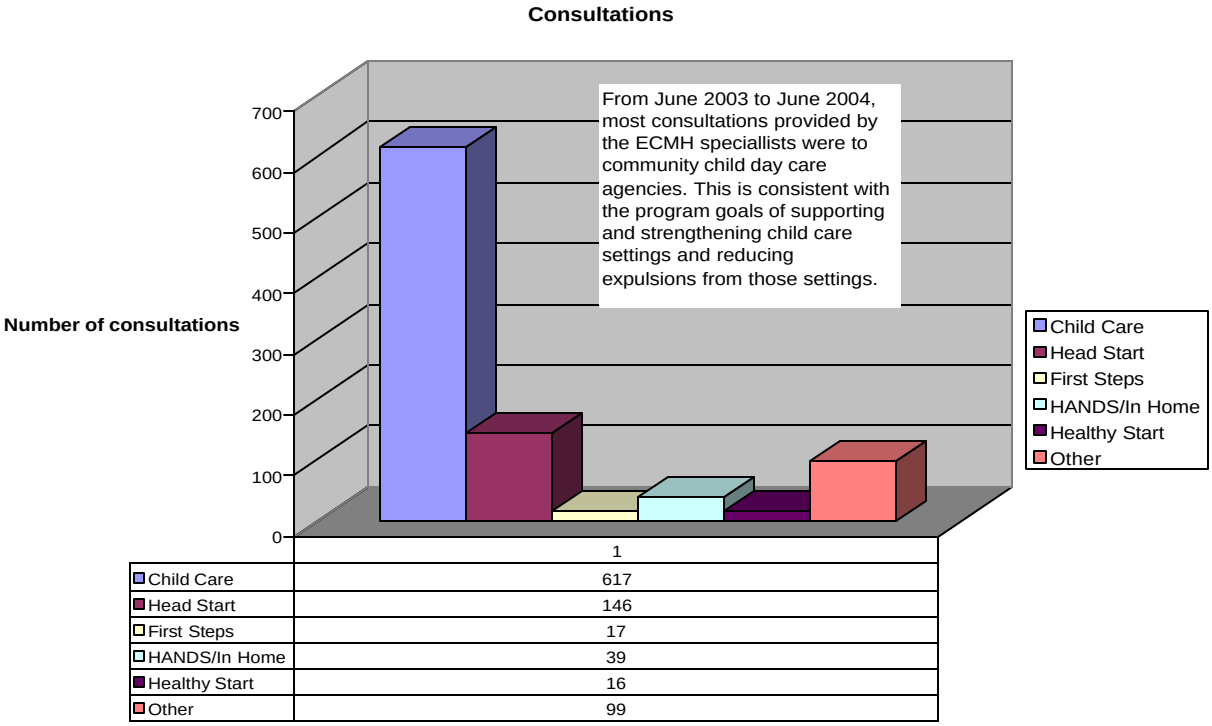
Group- and community-level interventions employed by ECMH Specialists

Over the course of the year, specialists also engaged in a variety of activities that focused on the group and system levels across the state.

With respect to training, specialists provided a high level of training to parents in the community. These tended to focus on topics such as: (1) social-emotional development; (2) parenting skills/behavior management; (3) diagnosis and (4) medications. Trainings provided to mental health professionals focused on (1) therapy techniques with young children; (2) assessment; (3) diagnosis and (4) early childhood behavior problems. Specialists also provided limited trainings for other professionals on behavior management and the ECMH referral process.

Of the consultation services provided by the specialists, most tended to focus on (1) behavior management; (2) child development and (3) the process of referring and linking to services. Child care centers were the largest recipients of consultation services.





	1
Child Care	617
Head Start	146
First Steps	17
HANDS/In Home	39
Healthy Start	16
Other	99

Across the state, specialists reported a variety of public awareness and marketing activities within which they engaged for the purposes of promoting the ECMH program in their communities. These include (1) sponsoring information booths at community fairs; (2) providing brochures to day care centers, primary physicians, etc; (3) facilitating articles in local newspapers on children's issues and (4) conducting regular visits to child care centers to build rapport and trust with staff.

Similar to the previous year, most specialists participated in many system-level activities which included attendance at: (1) Early Childhood councils; (2) RIAC meetings; (3) child care coalition meetings; (4) child care director meetings; (5) FRYSC council meetings, and numerous similar activities.

ECMH program implementation, successes and ongoing challenges

While specialists demonstrated different approaches to structuring and organizing the programs within their regions, all seem to be functioning at capacity. Naturally, the mental health needs of this population and the available resources vary from community to community across the state and specialists

appear to have a good understanding of these issues with respect to their regions.

There are a number of ongoing challenges with which the ECMH specialists are coping. Many reported continued efforts to gain the trust of child care center staff, particularly directors. While most centers appreciate the service that the specialists provide, some directors and staff are suspicious and fearful that they are being negatively evaluated and could be closed down. Specialists are making focused efforts to address these issues with the child centers in their communities.

Lack of mental health resources for children ages 0 to 5 was also cited as a problem. Several regions have few, if any, therapists trained or interested in working with this population. Consequently, these ECMH specialists spend considerable time providing direct individual services. Relatedly, a few specialists reported providing little direct service but rather focused their efforts on group and system level activities due to having more therapists to whom they could refer. They felt that they could be more effective and reach more children and families by referring and linking to other service providers.

All specialists reported the mental health needs for children in their regions to be so great that they do not have the time to address them all. Because of the large work load, each felt that the addition of another specialist in their region would help make the program more effective in reaching a greater number of needy children and families. Many presented the rationale for additional specialists in terms of cost-effectiveness: it would be less expensive to address child and family problems earlier rather than later when such problems may be more entrenched. The size of some regions and the long driving times also contributed to their frustration.

Many specialists reported a sub-population of children and families that have the greatest needs and are the most difficult to engage. Often these parents will seek help only when they are in crisis but refuse ongoing services once the crisis has abated. This is frustrating for specialists as they feel that they are only putting out fires without addressing the core problems. Parents will frequently come in seeking a quick and easy fix, usually medication, for their child's behavior and are often resistant to viewing the problem in terms of parenting and behavior management.

A variety of programmatic successes were noted by the specialists. These successes include providing services to a population that was previously severely underserved. It was felt that a service void existed prior to the implementation of the program. Many specialists also reported the consultation and training services that they provide to be a valuable component of their program, as they are able to reach more children and families by these activities. They also felt that their efforts to develop networks between other professionals and relevant community members were a successful and important part of their role. Other positive aspects mentioned were the freedom

the specialists have to self-manage the program and the ability to get out of their offices and work with children in their homes or communities. As one specialist explained, they can meet in the child's environment where the problems actually occur rather than their office where they do not.

Appendix

Structured Interview of ECMH Specialists
(for purposes of program evaluation)

Regional Program Information

When did your ECMH program begin to operate (mo./year)? How long have you worked in this position?

What is your background and training with respect to early childhood? Mental health?

Describe the communities you serve

How many counties are in your area?

Urban/suburban/rural?

Availability of quality child care?

Attitude toward mental health?

Socioeconomic factors?

Special issues or concerns?

Individual Child and Family Level
(targeted recipients of services)

Evaluation Questions to be Addressed:

- ***Who is Being Served by Your Program?***
- ***What Services are Being Delivered?***
- ***What Outcomes are Associated with Individual-Level Program Participation?***

How many referrals have you received? Who are your primary referral sources? Proportionately?

Is the referral process effective?

How many children have you accepted into your program?

_____ How many of these have you been able to engage in intervention? Of these, how many were:

_____ Fully engaged
_____ Partially engaged

How many are active on your caseload at present?

How many have you exited/completed?

How many have dropped out?

Thinking about all of the young children you have served individually through assessment, intervention, and case management, what percentage of your "cases" are referred for atypical development (suspect developmental disorder such as autism, mental retardation, childhood schizophrenia, ADHD, or other biologically-based problems), versus the percentage of cases that are most likely attributable to problems within the family and home (e.g., parenting, nurturing, parental mental illness or substance abuse, domestic violence, family conflict, neglect, etc.).

_____ Atypical development/developmental disorders (%)
_____ Family/home problems or risks (%)

(Should add up to 100%)

Thinking about all of the young children you have accepted into your program and served individually through assessment, intervention, and case management, as precisely as possible provide a number showing how many of these experience the following problem, risk, and resilience factors (e.g., if you have served 30 kids individually, and 2/3 have history of parental mental illness, put a 20 on that line). It is expected that a given child/family will have multiple risk/resilience factors present.

Child problems
_____ Child anxiety/depression
_____ Child over-aggressiveness
_____ Child over-activity
_____ Child impulsivity
_____ Child defiance
_____ Child disengagement, withdrawal
_____ Child handicapping conditions
_____ Child health disorders
_____ Child dysregulation (fussiness, sleep & feeding problems)
_____ Child failure to thrive

Family risks

_____ Low socioeconomic status
_____ Parent unemployed
_____ Single parent
_____ History of parent mental illness
_____ History of parent substance abuse
_____ Substantiated physical abuse
_____ Substantiated sexual abuse
_____ High levels of family conflict
_____ Parent-child interaction problems
_____ Chaotic home environment
_____ Domestic violence
_____ Multi-stressed family
_____ Limited social support, social isolation

Resilience/protective factors

_____ Engaged primary caregiver
_____ Warm and sensitive caregiving environment
_____ Adequate nutrition
_____ Opportunities for exploration and play
_____ Available, quality child care (kin, child care centers)
_____ Available well-child health care

Of your total caseload since the beginning of the program, how many have you served on an individual level and in a direct fashion through:

_____ individual assessment,
_____ individual therapy (office or home-based)
_____ individual parent training & family work
_____ individual consultation with other caregivers (e.g., child care)

_____ individual consultation with other professionals (e.g., therapists, home visitors)
_____ individual linking and coordinating of services (i.e., case management)

Thinking about the "cases" you have completed or nearly completed, what % have been successful, partially successful, not successful, based on attainment of goals? Based on how many cases?

Of these completed cases (n=), how many focused on:

_____ reduction of problem behaviors (# successful _____) – Give examples

_____ parent/child management skill development (# successful _____) – Give examples

_____ parent-child interactions (# successful _____) – Give examples

_____ family conflict/cohesiveness (# successful _____) – Give examples

_____ risk reduction (# successful _____) – Give examples

_____ developmental gains (# successful _____) –Give examples

_____ increased opportunities (# successful) – Give examples

_____ increased protective factor (# successful) – Give examples

Have you been able to prevent any children from being discharged from child care settings? How many? Give details.

Have you been able to prevent any children from being hospitalized? How many? Give details.

Group- and System-Level Activities

Other than consultations done for specific individual children, have you done group- or program-level consultations in your region? What programs or organizations have you consulted with?

What training and support have you provided to parents and families through activities such as general parenting skills, developmental issues, etc. (not individual consultation described above)? How many? On what kinds of issues and problems have you focused? Evidence of success?

Child care? How many? What has been the nature of the consultation? How extensive has your involvement been? Evidence of success?

Early Head Start & Head Start? How many? What has been the nature of the consultation? How extensive has your involvement been? Evidence of success?

Home visitors? How many? What has been the nature of the consultation? How extensive has your involvement been? Evidence of success?

What training and support have you provided to other mental health professionals (not the individual consultation described above)? How many? On what kinds of issues and problems have you focused? Evidence of success?

What training and support have you provided to other health professionals, such as primary care physicians (not the individual consultation described above)? How many? On what kinds of issues and problems have you focused? Evidence of success?

What community-level public awareness and planning activities have you done? Who was involved? What was your role? Evidence of success?

What challenges have you faced in establishing your program? What continuing program-level challenges are you working on?

What are the strengths of the program? What has been most successful?

How do you make decisions about where to focus your time and effort?

What education, training, and support are needed to perform this role?

How well does the role integrate with other mental health services and programs?

How would you characterize your relationship with Healthy Start? With your Comprehensive Care Center.

What needs do you perceive in your community? How many young children need mental health services? What are the most prominent issues and concerns within this population?